the pylorus; the second, irregular in shape, was 1.5 cm. lower; the third and smallest, about the same distance below the second; the first penetrated the apex, the last involved the base of the gall-bladder. Upon each of the three openings lay a gall-stone, and from the neighborhood of the stones upon light pressure blood flowed into the intestine from the gall-bladder, as likewise from the ductus choledochus, through the papilla, which lay about 2 cm. below the third perforation. Near the three stones a blood-filled ovoid sac, about 6 cm. long and 3 cm. in greatest diameter, overlay the gall-bladder, into which it opened by a perforation near the apex, in relation with an abnormal communication between the gall-bladder and the hepatic duct near the division of the latter; and here the lumen of the sac was continuous with that of a ring-shaped body, which blocked and dilated the hepatic duct, and overlay the abnormal opening described. At this place a circular opening 3 to 4 cm. in diameter was covered by a valve-like projection or ruffling of the mucous membrane; and this opening led directly into the right branch of the hepatic artery.

In the neighborhood of the projecting valve the lining membrane of the duct was roughened, and showed a number of small superficial ulcers. About 1 cm. nearer the duodenum two larger ulcers were found. The hepatic duct was much distended near the site of the perforation, but narrowed further on, and again widened, together with the common duct, near the duodenum. Above the aneurism the bile-ducts were but slightly dilated. The lumen of the hepatic artery was free from obstruction; the edges of the opening were smooth, while the arterial wall projected as the inner lining of the circular ruffle-like valve in the lumen of the hepatic duct. There was no arteriosclerosis. Microscopic examination showed nothing of arterial wall or other organized tissue either in the basal ring-shaped portion of the false aneurism or in the ovoid sac.

Schmidt finds records of but five cases of hepatic aneurism in which rupture and hemorrhage took place through the bile-ducts.

SURGERY.

UNDER THE CHARGE OF

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ILEO-COLOSTOMY.

AN interesting case of ileo-colostomy by means of Senn's method of lateral anastomosis modified by the use of prepared vegetable plates, is reported by v. BARACZ (*Centralbl. für Chir.*, July 7, 1894). The resected portion, consisting of the cæcum and portions of the colon and ileum, was not removed, on account of adhesions and malignant involvement, but the ends were sutured, and it was left within the abdominal cavity without any external outlet. The author draws the following conclusions from the case: 1. In man the resected and closed portion of gut left within the abdomen produces very little or no excretion. 2. Therefore this method of procedure is not so harmful as has sometimes been supposed, and the bursting of the intestine from the collection of intestinal excreta is not to be feared. 3. This method is especially applicable to cases of intestinal obstruction due to invagination or malignant disease. He considers the method more rational than simple anastomosis, as it prevents the irritation of the diseased part by the passage of the intestinal contents over it. 4. Senn's method, modified by using prepared vegetable plates, is preferable, the prepared turnip plates never producing necrosis and perforation, as has occurred with bone plate not sufficiently decalcified.

THE OPERATIVE TREATMENT OF RUPTURED URETHRA.

DEANESLY (*The Practitioner*, July, 1894) points out the fact that rupture of the urethra occurs almost always in one of two situations: either in the immediate neighborhood of the bulb or in the membranous portion. If divided in front of the triangular ligament the classical symptoms follow. "When, however, the urethra is ruptured behind the triangular ligament in cases of fractured pelvis, extravasation occurs in the prevesical space between the bladder and the pubis, where a considerable quantity of urine may collect. This fact sometimes leads to a fallacy. A catheter is passed, following the roof of the urethra, and keeping the point strictly in the middle line. On depressing the handle between the legs the catheter enters a space in which it is freely movable from side to side, and from which five or six ounces of clear urine may be withdrawn. By the rectum the catheter feels exactly as if in the bladder, although it is in reality in the prevesical space." In regard to treatment the author believes that in all cases of rupture of the bulbous portion of the urethra, and also where a blow upon the perineum has produced free bleeding from the urethra, the latter should be exposed and examined, whether a catheter can be introduced or not. The catheter may prevent extravasation, but in no way prevents the formation of a most intractable stricture. If the urethra has been completely divided, the ends should be carefully and accurately sutured. The bruised or lacerated portion should be resected. The author advises the use of a non-absorbable suture—silkworm gut, horse-hair, or fine silver wire, the sutures to be removed later, the ends being left long for this purpose and brought out of the wound, or the wound may be left open. He does not use absorbable sutures on account of the liability to contamination of the wound by urine, which prevents their enclosure or absorption. The sutures should include the whole thickness of the urethra except the mucous membrane, and care should be taken not to fold the edges of this into the wound. Four sutures are usually enough. The perineal wound may be accurately sutured, the stitches including the bulbo-cavernosus muscle, or it may be left open. In cases where the rupture is only partial, the fibrous sheath remaining intact, the author would advise